STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395466	A. BLDG: 00 B. WING:	05/04/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MILFORD HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: **133602**	**264 ROUTE 6 & 209** **MILFORD, PA 18337**

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E 0000	INITIAL COMMENT A COVID-19 Focused Emergency Preparedness Survey was conducted by The Department of Health (DOH). Milford Healthcare and Rehabilitation Center was in compliance with 42 CFR 483.73 related to E-0024(b)(6)	E 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0000	INITIAL COMMENT Based on a revisit, abbreviated complaint and focused infection control survey completed on May 4, 2023, it was determined that Milford Healthcare and Rehabilitation Center corrected the federal deficiency cited during the survey of March 29, 2023, but continued to be out of compliance with the following requirements of 42 CFR Part 483 Subpart B Requirements for Long Term Care and the 28 PA Code Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0584 SS=E		F 0584		

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F 0584 SS=E	Continued from page 1 483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all	F 0584	1.Room 103 floor, beds, furniture will be cleaned and screws and blade left in room from remodeling had been removed from room during survey. Room 104-Ceiling Tiles with brown stains were replaced with new tiles. Room 105 floor will be cleaned, unit panel that was off during survey was due to unit being replaced that day and unit was put back together during survey. Room 105 bedside tables/dresser will have handles placed on. Room 105 bathroom floor will be cleaned. Room 105 toilet that had brown stain will be cleaned. Room 107-ladder was removed and was out due to remodeling on that unit, room 107 floor will be cleaned, room 107-bathroom ceiling tiles will be added and old stained tiles will be replaced, Room 107-after deep cleaning beds will be made. Room 108-coveres to night lights will be fixed ensuring no exposing wires are showing. Room 108 bathroom-cover to light will be placed over light. Room 108 bathroom and room ceiling tiles will	Completion Date: **05/23/2023** Status: **APPROVED** Date: **05/15/2023**

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F 0584 SS=E	Continued from page 2 areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by:	F 0584	be reviewed and replaced to ensure all tiles are in place and no stains are visible. Room 108 bathroom will be checked to ensure there spray attachment connected to toilet is not on the floor. 2. Facility will audit and perform a physical environmental audit on unit 1's rooms and bathrooms (unit 1 is the unit being remodeled and where citations occurred) to ensure the unit is maintained in an orderly, clean and safe manner. 3. NHA/Designee will educate housekeeping staff and Maintenace staff on facilities Homelike environment policy as well as facilities physical environmental audit tool to ensure a safe, clean, and homelike environment is maintained. 4. NHA/Designee will audit 3 rooms 5 days a week x 4 weeks than monthly x 2 months using facilities environmental audit tool to ensure	

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F 0584 SS=E	Continued from page 3	F 0584	the facility areas are maintained in an orderly, clean and safe manner.Results will be reviewed in QAPI.	

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F 0584 SS=E	Continued from page 4 Based on observations and staff interview, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a clean, safe and orderly environment in the facility on one of two resident floors (first floor). Findings include: Observations conducted during a tour of the facility and resident rooms on May 4, 2023, at approximately 9:30 AM revealed the following: In unoccupied resident room 103 the floor was dirty, visible dirt, dried liquid stains and paper debris were observed on the floor of this room. The two beds in the room were unmade and the mattresses were observed to be dirty, dusty and and	F 0584		

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F 0584 SS=E	Continued from page 5 stained with dried liquids. Several loose metal screws were observed on top of bed 1 and on the adjacent overbed table. A large wall mirror was also on top of the bed. Several loose metal screws, a razor blade and a wall mirror were observed placed on top of the table connected to the wardrobe in the room. In resident room 104, there was a large brown water stain on a ceiling tile. In resident room 105 the floor was observed to be soiled with dirt and dried liquid stains. The front panel was off the heating/cooling unit. There were two three drawer bedside tables in the room, both of which were lacking drawer handles. In the bathroom of this resident room, the floor was visibly dirty and dried liquid stains were observed. A large	F 0584		

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F 0584 SS=E	Continued from page 6 brown stain was observed in the toilet bowl. A ladder was observed propped up in resident room 107. The room floor of the room was visibly dirty and dried liquid stains were observed. Both beds in the room were unmade. The mattresses were observed to be soiled with dirt and were stained. Folded bed linens were observed on top of both beds in the room. In the bathroom, there was a missing ceiling tile with insulation hanging out of the ceiling. In resident room 108, the cover was off both night lights positioned outside and inside the resident bathroom, exposing the electric socket and the light bulbs. Inside the bathroom, the cover was off the light switch on the wall. There was a missing ceiling tile in the bathroom. There was a	F 0584		

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F 0584 SS=E	Continued from page 7 spray attachment, connected to the water supply to the toilet, observed laying on the floor. During an interview May 4, 2023 at 4 P.M., the Nursing Home Administrator confirmed that the facility should be maintained in an orderly, clean and safe manner. 28 Pa. Code 207.2(a) Administrator's Responsibility.	F 0584		

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F 0584 SS=E	Continued from page 8	F 0584		
F 0610 SS=D	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate	F 0610	1. Facility can not retroactively correct. 2. Employee #1 no longer works at the facility. 3.DON/Designee will educate nursing staff on abuse policy and reporting guidelines to ensure staff are reporting abuse in a timely. 4.NHA/Designee will audit abuse allegations/investigations weekly x 4 weeks than monthly x 2 months to ensure the facility is investigating and reporting allegations timely. results will be reviewed in QAPI.	Completion Date: **05/23/2023** Status: **APPROVED** Date: **05/15/2023**

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F 0610 SS=D	Continued from page 9 corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 0610		

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F 0610 SS=D	Continued from page 10 Based on review of clinical records, facility incident investigation, and the facility's abuse prohibition policy and staff interview, it was determined that the facility failed to timely report and investigate an allegation of resident abuse and prevent the potential for further abuse during the course of the investigation for one resident out of 18 residents sampled (Resident 4). Findings include: Review of the facility's Abuse Policy, dated as reviewed by the facility August 2022 revealed that steps will be taken to prevent further potential abuse, and should include the immediate suspension of the employee pending outcome of the investigation Clinical record review revealed Resident 4 was admitted to the facility on January 15, 2023, with diagnoses to include dementia.	F 0610		

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F 0610 SS=D	Continued from page 11 A review of a quarterly MDS assessment dated April 1, 2023, (Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care) revealed that Resident 4 was severely cognitively impaired and required maximum assistance of staff for activities of daily living. A review of a facility investigation revealed that on April 30, 2023, at 6:15 PM, the Director of Nursing was informed that Employee 3, a nurse aide, informed Employee 2 (RN Supervisor 7 AM to 3 PM) that on April 29, 2023, during the 11 PM to 7 AM shift, Employee 3 (nurse aide) heard Employee 1 (RN Supervisor) yelling and making verbal threats to Resident 4, stating "If you don't shut up, I will tell Employee 3 (nurse aide) to get you up and give you a shower. Employee 1 (RN) kept repeating to Resident 4, "shut the f--k up, I'm tired of those moaning sounds. Employee 3 told Employee 1 "to stop, the other residents are listening." A review of a witness statement, no date or time	F 0610		

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F 0610 SS=D	Continued from page 12 noted, revealed that Employee 3 stated that "On April 30, 2023, I was doing my rounds, coming in and out of residents rooms, but around 6 A.M., I was on Room 206-C providing care to a resident when I overheard next door yelling and screaming. I saw Employee 1 (RN) going into room 205-B (Resident 4's room). I followed her and stood by the door outside. Employee 1(RN) repeatedly said to Resident 4, "shut the f--k up. "F--k, f--k me, that I have to hear this moaning and crying all night. I told you to shut up 3 times, but you are not listening. One more time and I will make the nurse aide get you out of that bed and give you a shower. At this time, Employee 1 (RN) was in Resident 4's room. She then left the residents room and went into the hallway, continuing to yell. I told her to stop yelling, that she was scaring the residents, but she would not listen. She told me (Employee 3) to shut up too. At this point, I was scared too. I didn't know what to do. I only kept an eye on her." A review of a witness statement, no date or time noted, revealed that the Director of Nursing (DON)	F 0610		

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F 0610 SS=D	Continued from page 13 stated "On April 30, 2023, at approximately 7:30 P.M. I called Employee 1 (RN) to inform her that she was being suspended pending the outcome of the allegation of verbal abuse. An interview May 4, 2023, at approximately 4 PM., the Director of Nursing stated that Employee 1 was the RN nursing supervisor on duty April 29, 2023, 11 PM to 7 AM shift. The DON confirmed that Employee 3, nurse aide, did not immediately report the alleged verbal abuse of Resident 4 by Employee 1. Employee 1 continued to work the remainder of the shift. Employee 1 was not suspended until 7 PM on April 30, 2023, which failed to protect residents from the potential for further abuse during the remainder of Employee 1's shift. The allegation of abuse of Resident 4 was not immediately reported and the alleged perpetrator was not immediately suspended pending the investigation as noted in facility policy.	F 0610		

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F 0610 SS=D	Continued from page 14 28 Pa. Code 201.14(a)(c)(e) Responsibility of Licensee 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(a)(c)(d) Resident rights	F 0610		
F 0623 SS=B		F 0623		

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F 0623 SS=B	Continued from page 15 483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)	F 0623	1.Facility can not retroactively correct. Facility sent notices of monthly transfers January 2023 thru April 2023 to Ombudsman during survey. 2.Facility sent notices of monthly transfers January 2023 thru April 2023 to state LTC Ombudsman. 3.NHA/Designee will educate BOM on sending monthly transfers to the state long term ombudsman monthly. 4. NHA/Designee will audit monthly x 2 months to ensure state long term ombudsman is receiving monthly transfers each month. Results will be reviewed in QAPI.	Completion Date: **05/23/2023** Status: **APPROVED** Date: **05/15/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395466	A. BLDG: __00_____ B. WING: _____	05/04/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MILFORD HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: 133602	264 ROUTE 6 & 209 MILFORD, PA 18337

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F 0623 SS=B	Continued from page 16 (1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and	F 0623		

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F 0623 SS=B	Continued from page 17 (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by:	F 0623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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F 0623 SS=B	Continued from page 18 Based on a review of clinical records and facility documentation and staff interviews it was determined that the facility failed to send a copy of notices of facility initiated transfers and discharges to a representative of the office of the State Long-Term Ombudsman. Findings include: At the time of the survey ending May 4, 2023, there was no documented evidence that the facility had sent copies of the notices of facility initiated transfers and discharges to a representative of the Office of the state long-term care ombudsman for the resident transfers and discharges that had occurred during the months of January 2023 and February 2023.	F 0623		

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MILFORD HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: **133602**	**264 ROUTE 6 & 209 MILFORD, PA 18337**

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F 0623 SS=B	Continued from page 19 An interview dated May 4, 2023, the corporate nurse consultant confirmed that the facility was unable to provide evidence that copies of the notices of facility initiated transfers and discharges that had occurred during the months of January 2023 and February 2023 had been sent to a representative of Office of the State Long Term Ombudsman. 28 Pa Code 201.29 (h) Resident Rights 28 Pa Code 201.14 (a) Responsibility of Licensee	F 0623		

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	395466	A. BLDG: 00 B. WING:	05/04/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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F 0645 SS=D	483.20(k)(1)-(3) PASARR Screening for MD & ID §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility,	F 0645	1. Facility can not retroactively correct. Resident CR3 no longer resides at the facility. 2. Facility will do a 2 week look back on new admissions to ensure a PASRR is conducted and completed and maintained in the residents clinical record. 3.NHA/Designee will educate Admission coordinator and social service assistant on screening and completion of PASRR prior to admission. 4.NHA/Designee will audit new admissions weekly x 4 weeks then monthly x 2 months to ensure screening and completion of PASRR is completed and maintained in the residents clinical record. Results will be reviewed in QAPI.	Completion Date: **05/23/2023** Status: **APPROVED** Date: **05/16/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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F 0645 SS=D	Continued from page 21 was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by:	F 0645		

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F 0645 SS=D	Continued from page 22 Based on clinical record review and staff interview it was determined that the facility failed to conduct a PASRR (Preadmission Screening and Resident Review) for one of 18 residents reviewed (Resident CR3). Findings include: The PASRR (Preadmission Screening Resident Review) was created in 1987, through language in the Omnibus Budget Reconciliation Act (OBRA) and it has three goals: to identify individuals with mental illness and/or intellectual disability, to ensure they are placed appropriately, whether in the community or in a nursing facility, and to ensure they receive the services they require for their mental illness or intellectual disability. The PASRR Level 1 must be completed on all persons who are considering admission to a Medicaid certified nursing facility. A Level II PASRR evaluation must be completed if the Level 1	F 0645		

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F 0645 SS=D	Continued from page 23 PASRR determined that the person is a targeted person with mental illness or an intellectual disability. The Level II PASRR would determine if placement or continued stay in the requested or current nursing facility is appropriate. Review of Resident CR3's clinical record revealed that the resident was admitted to the facility on October 3, 2022, with diagnoses that included schizophrenia (a serious mental health condition of a type involving a breakdown in relation between thought, emotion, and behavior), bipolar disorder (a mental health condition that causes extreme mood swings that include emotional highs and lows), and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). Review of Resident CR3's clinical record did not include a PASRR completed prior to this resident's admission of October 3, 2022.	F 0645		

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F 0645 SS=D	Continued from page 24 Interview with the Nursing Home Administrator on May 4, 2023, at 6:30 PM was unable to provide documented evidence that a PASRR was completed and maintained in this resident's clinical record. The facility failed to ensure the resident was screened for a MD-ID prior to her admission, as required, to ensure that if Resident CR3 was identified prior to her admission with a MD-ID (Diagnostic manual-Intellectual disability), Resident CR3 would have been evaluated, and would have received care and services in the most integrated setting that was appropriate for the resident's needs. 28 Pa Code 201.8(b)(1)(e)(1) Management 28 Pa Code 211.5(f) Clinical records	F 0645		

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F 0645 SS=D	Continued from page 25	F 0645		
F 0684 SS=D		F 0684		

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F 0684 SS=D	Continued from page 26 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	1. Facility can not retroactively correct. CR3 no longer resides at the facility. 2.DON/Designee will audit the past 2 weeks of the facilities mental health provider consults/recommendations to ensure follow up and MD review is/was followed and completed. 3. NHA/Designee will educate DON and ADON on ensuring consults/recommendations from the mental health provider are followed up and reviewed by MD in a timely manor. 4.DON/Designee will audit 3 mental health consults/recommendations weekly x 4 weeks to ensure recommendations are reviewed by MD and followed up with in a timely manor. results will be reviewed in QAPI.	Completion Date: **05/23/2023** Status: **APPROVED** Date: **05/15/2023**

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F 0684 SS=D	Continued from page 27 Based on a review of clinical records and staff interviews, it was determined that the facility failed to provide person-centered care, according to professional standards of nursing practice, by failing to timely communicate recommendations from consulting providers to the resident's attending physician to ensure the resident's treatment goals are met for one resident out of 18 sampled residents. (Resident CR3). Findings include: According to the American Nurses Association Principles for Nursing Documentation, nurses document their work and outcomes and provide an integrated, real-time method of informing the health care team about the patient status. Timely documentation of the following types of information should be made and maintained in a patient's EHR (electronic health record) to support the ability of the health care team to ensure informed decisions and high-quality care in the continuity of patient care: · Assessments	F 0684		

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F 0684 SS=D	Continued from page 28 · Clinical problems · Communications with other health care professionals regarding the patient · Communication with and education of the patient, family, and the patient ' s designated support person and other third parties. Review of Resident CR3's clinical record revealed that the resident was admitted to the facility on October 3, 2022, with diagnoses that included schizophrenia (a serious mental health condition of a type involving a breakdown in relation between thought, emotion and behavior), bipolar disorder (a mental health condition that causes extreme mood swings that include emotional highs and lows), and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). The resident was receiving physician prescribed lithium (a mood stabilizer in which toxic levels are	F 0684		

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F 0684 SS=D	Continued from page 29 near therapeutic levels, and signs of toxicity include tremor, ataxia, diarrhea, vomiting, and sedation) throughout the resident's stay at the facility. .A review of Resident CR3's care plan revealed that the resident's use of lithium and necessary monitoring to include signs and symptoms of lithium toxicity were not included on the resident's plan of care. A review of a consultant mental health provider documentation dated February 3, 2023, revealed a recommendation to obtain a "lithium level if one not done already." (Lithium levels are monitored on a regular basis because blood levels must be maintained within a narrow therapeutic range. Too little and the medication will not be effective; too much and symptoms associated with lithium toxicity may develop) A review of the resident's clinical record revealed that a lithium level was completed on February 24, 2023, 21 days after the consultant's request.	F 0684		

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F 0684 SS=D	Continued from page 30 Further review of a consultant mental health provider documentation dated March 16, 2023, revealed another recommendation for a lithium level to be obtained. At the time of the survey ending May 10, 2023, there was no documented evidence that this recommendation had been acted upon. A nursing note dated March 24, 2023, at 1326 (1:26 PM) indicated that "Resident being transferred out to the hospital. Due to lethargy, difficult to arouse, and prolonged apneic moments." During an interview on May 4, 2023, at approximately 2:00 PM, with the Director of Nursing, the DON stated that when the consultant mental health provider makes recommendations, this information in verbally relayed to the nurse, and the nurse is to reach out to the physician to review recommendations and obtain orders. Additionally, the DON confirmed there was no documented	F 0684		

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MILFORD HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: **133602**	**264 ROUTE 6 & 209** **MILFORD, PA 18337**

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F 0684 SS=D	Continued from page 31 evidence of physician communication regarding the request for a lithium level on March 16, 2023, or that a level had been obtained prior to the resident's hospital transfer. 28 Pa. Code 211.12 (a)(c)(d)(1)(3)(5) Nursing services 28 Pa. Code 211.5(f)(g)(h) Clinical records.	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395466	A. BLDG: __00_____ B. WING: _____	05/04/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MILFORD HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: **133602**	**264 ROUTE 6 & 209** **MILFORD, PA 18337**

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F 0684 SS=D	Continued from page 32	F 0684		
F 0689 SS=D		F 0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MILFORD HEALTHCARE AND REHABILITATION CENTER	**264 ROUTE 6 & 209 MILFORD, PA 18337**
STATE LICENSE NUMBER: **133602**	

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F 0689 SS=D	Continued from page 33 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 0689	1.Facility can not retroactively correct.Facility will set up a care plan conference with resident #5 family to ensure they are educated and understand residents transfer status as well as signing resident out when leaving. 2.DON/Designee will do a 1 week look back on fall incidents to ensure proper investigation is completed and appropriate interventions are in place with attesting in the investigation its self that current interventions are/were in place. 3.Regional nurse consultant/Designee will educate DON and ADON on proper fall investigation protocol along with care plan updating and review. 4.DON/Designee will audit 3 falls a week x 4 weeks than monthly x 2 months to ensure investigation is completed and care plan reflects current interventions along with new interventions. Results will be reviewed in QAPI.	Completion Date: **05/23/2023** Status: **APPROVED** Date: **05/16/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MILFORD HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: 133602	264 ROUTE 6 & 209 MILFORD, PA 18337

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F 0689 SS=D	Continued from page 34 Based on review of clinical records and select resident incident/accident reports and staff interview, it was determined that the facility failed to demonstrate the implementation of planned measures and necessary staff supervision of a resident at risk for falls and displaying unsafe behavior (Resident 1) and failed to ensure safe transfers of one resident (Resident 5) to prevent falls out of 18 sampled residents. Findings include: A review of the clinical record revealed Resident 1 was admitted to the facility on April 16, 2023, with diagnoses to include a history of falling, multiple fractures of ribs, and cognitive communication deficit. A review of Resident 1's care plan dated April 17, 2023, revealed that the resident was at risk for falls due to history of falls, impaired balance/poor coordination, and unsteady gait. The goal was to	F 0689		

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MILFORD HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: 133602	264 ROUTE 6 & 209 MILFORD, PA 18337

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F 0689 SS=D	Continued from page 35 minimize the risk for injury related to falls with planned interventions of the use of a bed bed alarm, chair alarm, maintain bed in low position, and provide assistance to transfer and ambulate. A review of the incident accident report dated April 29, 2023, at 2:10 AM indicated that Resident 1 had an unwitnessed fall. "At 02:10 AM resident heard yelling. RN responded to resident's room found resident lying on left side on the floor. Resident was on the floor between the bed and the nightstand. Resident AAO (alert and oriented) x 1, able to follow simple commands. Bed found in the lowest position. Call bell attached to bedding." The resident was assessed and transferred to an acute care hospital A nurse's note dated April 29, 2023, and timed at 2:42 AM (after the resident's fall at 2:10 AM) indicated that from 11 PM through 2:20 AM the resident had been constantly yelling and screaming with severe confusion. Nursing noted that the resident required 1:1 at times. The resident's bed	F 0689		

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MILFORD HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: 133602	264 ROUTE 6 & 209 MILFORD, PA 18337

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F 0689 SS=D	Continued from page 36 was noted to be in the lowest position. The resident was stating that could not breathe and rated pain at a "20" on a scale of 1-10 (with 10 being the most severe). Nursing administered Tramadol to the resident at 10:15 PM. Nursing noted that the resident was continuously yelling and ringing the call bell. The resident thought she was in the hospital and wanted to go home. According to nursing documentation, an RN looked for a room closer to the nurse's station but none were available. Nursing administered the antipsychotic drug Seroquel 50 mg and melatonin 5 mg to the resident at 1 AM. The facility's report of this fall failed to identify if the resident's alarms had been in place and sounding to alert staff to the resident's fall. The facility's investigation failed to reflect the provision of necessary supervision of the resident during her period of increased confusion as the subsequent nursing entry noted that the resident required 1:1 status. Staff also medicated the resident with an antipsychotic drug and supplement to control her behavior and promote sleep.	F 0689		

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F 0689 SS=D	Continued from page 37 At the time of the survey ending May 4, 2023, the resident had been readmitted to the facility and the bed alarm and chair were removed from the resident's care plan as planned interventions to prevent falls. An interview with the Nursing Home Administrator on May 4, 2023, at approximately 6:00 PM, confirmed that the facility failed to demonstrate that the staff adequately and consistently supervised Resident 1 in response to the resident's displays of severe confusion, anxiousness, agitation and altered mental status and that necessary interventions were in place to prevent this resident's fall. Clinical record revealed that Resident 5 was admitted to the facility on October 21, 2019, with diagnoses to include, diabetes, hypertension and peripheral vascular disease. A quarterly Minimum Data Set assessment dated March 24, 2023, revealed that the resident was	F 0689		

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F 0689 SS=D	Continued from page 38 moderately cognitively impaired and required maximum assistance of 2 for transfers and maximum assistance of 1 for locomotion. The resident had a physician order, initiated August 8, 2022, indicating that the resident may go out on leave of absence. The resident's care plan did not address the resident's needs for assistance with transfers and locomotion while on leave of absence and how those needs for assistance with activities of daily living would be met while on LOA and communicated to the resident's family. A facility investigation dated April 9, 2023, at 11:15 A.M. revealed that Resident 5's family attempted to put the resident into their personal van and her knees buckled. The resident's family lowered her to the ground. The resident sustained an abrasion on her right knee. A review of a witness statement dated April 9, 2023, at 11:30 A.M., revealed that Employee 2 (RN) stated that Resident 5 was on her resident	F 0689		

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F 0689 SS=D	Continued from page 39 assignment at the time of the fall while attempting to get into her family's vehicle. She was passing medications at the time of the fall. A review of a witness statement dated April 9, 2023 at 11:40 A.M, Employee 4 (a nurse aide) stated that she was assigned to Resident 5 on the day of the fall. Employee 4 stated that the last time she saw the resident was when the resident was" leaving for church." A review of a witness statement dated April 9, 2023 at 11:15 A.M., revealed that the resident's son stated that "while trying to transfer mom to the car from the wheelchair, she stated "my knees," then her knee gave out." There was no evidence at the time of the survey that the facility had provided the resident's family education regarding the resident's transfer needs, including the use of two persons for transfers, to ensure safe transfers when transferring the resident into the car.	F 0689		

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F 0689 SS=D	Continued from page 40 An interview May 4, 2023 at 4 P.M., the corporate nurse consultant stated that residents and/or their responsible parties are to sign the resident out at the nurses desk. She further confirmed that Resident 5's family were educated on safe transfers prior to attempting to transfer the resident to their car for a leave of absence. 28 Pa. Code 211.12 (a)(c)(d)(1)(3)(5) Nursing services. 28 Pa. Code 211.11 (d) Resident care plan	F 0689		
F 0732 SS=C		F 0732		

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F 0732 SS=C	Continued from page 41 483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 0732	1. Facility can not retroactively correct. Daily nursing time was updated and posted during survey. 2.Facility can not retroactively correct. 3.NHA/Designee will educate DON, ADON, night shift nurse, scheduler and HR director on ensuring daily staffing time is posted and accurate per shift. 4. NHA/Designee will audit weekly x 4 weeks than monthly x 2 months facilities daily nursing time posting to ensure daily nursing time is posted and accurate reflecting the shift and day posted.results will be reviewed in QAPI	Completion Date: **05/23/2023** Status: **APPROVED** Date: **05/15/2023**

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F 0732 SS=C	Continued from page 42 §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by:	F 0732		

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F 0732 SS=C	Continued from page 43 Based on observation and staff interview, it was determined that the facility failed to post daily nursing time. Findings include: During an observation on May 4, 2023, at approximately 8:15 AM the facility's nursing time was not observed to be posted. An interview with the Nursing Home Administrator, at approximately 10:00 AM confirmed that the nursing time is to be posted at the beginning of each shift in a prominent location and readily accessible to residents and visitors. 28 Pa. Code 211.12 (c) Nursing services	F 0732		

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F 0732 SS=C	Continued from page 44 28 Pa. Code 201.18(e)(3) Management	F 0732		
F 0758 SS=D		F 0758		

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F 0758 SS=D	Continued from page 45 483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 0758	1.Facility can not retroactively correct. resident #1 no longer resides at the facility. 2.DON/Designee will audit current residents on a antipsychotic medication to ensure an appropriate DX is in order and if PRN there is a 14 day stop date with a re-assess. 3. DON/Designee will educate nursing staff to ensure residents on a antipsychotic medication have an appropriate DX is in their order and if PRN there is a 14 day stop date with a re-assess. 4. DON/Designee will audit 2 residents a week x 4 weeks than monthly x 2 months that are on a antipsychotic medication to ensure an appropriate DX is in the order and if PRN there is a 14 day stop date with a re-assess.results will be reviewed in QAPI	Completion Date: **05/23/2023** Status: **APPROVED** Date: **05/15/2023**

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F 0758 SS=D	Continued from page 46 §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:	F 0758		

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F 0758 SS=D	Continued from page 47 Based on a review of the clinical record and staff interview it was determined that the facility failed to ensure the presence of documented clinical indication for of the use of an antipsychotic drug prescribed on an as needed basis for one resident of 18 sampled (Resident 1). Findings: A review of the clinical record revealed Resident 1 was admitted to the facility on April 16, 2023, with diagnoses to include a history of falling, multiple fractures of ribs, and cognitive communication deficit. A review of the clinical record revealed Resident 1 was readmitted to the facility on April 28 2023, following a hospital stay.	F 0758		

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F 0758 SS=D	Continued from page 48 A physician order was obtained on April 28, 2023, at 22:30 (10:30 PM) for Quetiapine Fumarate Oral Tablet 50 mg (Seroquel), give 50 mg by mouth every 24 hours as needed (PRN) for agitation. The physician order for the prn antipsychotic drug did not include a stop date. A nurses noted dated April 29, 2023, and timed at 2:42 AM indicated "2300- 0220 (11:00 PM- 2:20 AM) Pt constantly yelling/screaming/severe confusion/forgetfulness/AMS (altered mental status)/EDP (emotionally disturbed) requiring 1:1 status at this time. Bed in lowest position. Pt reporting, she cannot breathe and pain is 20/10. Pt was medication at 22:15 with tramadol. Pt continuously yelling as well as ringing the call bell. Pt reports that she is in the	F 0758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395466	A. BLDG: 00 B. WING:	05/04/2023

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MILFORD HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: 133602	264 ROUTE 6 & 209 MILFORD, PA 18337

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F 0758 SS=D	Continued from page 49 hospital and wants to go home. RN looked for room closed to nurses' station. However, no rooms available at this time. Pt medicated with Seroquel 50 mg and melatonin 5 mg at 1 AM." The resident's clinical record did not reflect an assessment of the resident's physical complaint of inability to breathe. There was no documented assessment of the resident's respiratory status, such as sounds, respiration rate, or pulse oximetry prior to administering the antipsychotic drug and prior to a fall the resident subsequently sustained during the period of increased behaviors on April 29, 2023, at 2:10 AM. The resident's clinical record failed to contain documented evidence of the specific medical condition requiring	F 0758		

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F 0758 SS=D	Continued from page 50 treatment with the antipsychotic drug. Interview with the Nursing Home Administrator on May 4, 2023, at approximately 6:00 PM verified that there was no documented evidence from the clinical record that the medication was necessary to treat a diagnosed and documented medical condition and confirmed that the physician order for the antipsychotic PRN order did not have a stop date. 28 Pa. Code 211.2 (a) Physician services 28 Pa. Code 211.5 (f)(g) Clinical records	F 0758		
F 0880 SS=F		F 0880		

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F 0880 SS=F	Continued from page 51 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 0880	1. Facility can not retroactively correct. 2.Facility to do a 1 month look back to ensure a monthly infection control line listing with surveillance and mapping is up to date following infection control policy/program. 3.DON/Designee to educate ADON/ICP nurse on ensuring a monthly surveillance program with line listing is in place and is monitored. 4. DON/Designee will audit weekly x 4 weeks than monthly x 2 months facilities infection control line listing and surveillance to ensure facility is following infection control program and monitoring infections.	Completion Date: **05/23/2023** Status: **APPROVED** Date: **05/15/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0880 SS=F	Continued from page 52 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880		

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F 0880 SS=F	Continued from page 53	F 0880		

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F 0880 SS=F	Continued from page 54 Based on observations, review of clinical records, the facility's infection policy and infection tracking logs and staff interviews it was determined that the facility failed to maintain a comprehensive program to monitor the development and spread of infections within the facility and plan preventative measures accordingly. Findings include: A review of the current facility policy for Infection Control Program Overview, no review date available, revealed that an infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. A review of the facility's infection control	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0880 SS=F	Continued from page 55 data provided at the time of the survey ending May 4, 2023, revealed that the facility's infection control tracking did not reflect evidence of a tracking system to monitor and investigate potential causes of infection and manner of spread. There was no documented evidence of a system, which enabled the facility to analyze clusters, changes in prevalent organisms, or increases in the rate of infection in a timely manner. A review of facility's infection control data at the time of the survey ending May 4, 2023, revealed the following infections representing the facility's tracking and monitoring: "January 2023: skin-3, respiratory-3" A review of nursing documentation dated January 20, 2023, revealed that Resident 2	F 0880		

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F 0880 SS=F	Continued from page 56 had a new physician order for Antifungal external powder 2 %, apply to groin and left and right abdominal folds, topically twice a day for skin redness for 10 days. Nursing applied the antifungal medication to Resident 2 on January 20, 2023, through January 30, 2023, according to the January 2023 Medication Administration Record. A review of nursing documentation dated January 2, 2023 at 2:28 P.M. revealed Resident 3 had slight nasal congestion, was more confused and his lungs were clear. The physician was called and ordered blood work and a chest x-ray. There was no evidence that Resident 2's fungal infection was included in the tracking or that the Resident 3's	F 0880		

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F 0880 SS=F	Continued from page 57 respiratory symptoms were identified along with the diagnostic test results. At the time of the survey ending May 4, 2023, the facility did not have infection tracking logs for the month of February 2023. Nursing documentation dated February 2, 2023 revealed that Resident 2 had a physician order for antifungal external powder 2%, apply to the left abdominal fold topically twice a day for fungal rash for 10 days. According to the February 2023 MAR for February 2023 revealed that the antifungal powder was administered to Resident 2 from February 3, 2023, through February 13, 2023. According to the facility's March 2023	F 0880		

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F 0880 SS=F	Continued from page 58 and April 2023 infection tracking the following infections were noted: March 2023 - 9-skin infections, 5 infections referred to MDRO and 5-"other" infections. April 2023 - 9 -skin infections, 5 upper respiratory infections and 7-"other" infections and 5 urinary tract infections. The facility's infection control log revealed no documented evidence of detailed data collection that could be used by the facility to track these infections and to identify any potential trends contained in the tracking data. The data did not include resident room location or the infectious organism. There was no documented evidence at the time of the survey that based on the available tracking data that the facility had identified any	F 0880		

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F 0880 SS=F	Continued from page 59 possible trends in order to implement specific interventions to prevent the spread of any of the infections. There was no documentation by the facility of the infection start dates, resolution date, symptoms, complete culture information for any of the infections noted in the facility's monthly infection control tracking logs and the treatments required, if any. It could not be determined if any of the noted infections required isolation protocols to be implemented. There was no indication that the limited data that was compiled was then evaluated to determine what could be done to prevent the spread or recurrence of infection. During an interview conducted on Mat 4,	F 0880		

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F 0880 SS=F	Continued from page 60 2023, at approximately 3 PM the corporate nurse consultant (currently acting as the facility's designated Infection Preventionist) confirmed that the infection control tracking was incomplete and failed to include the necessary details to conduct routine, ongoing, and systematic collection, analysis, interpretation, and dissemination of surveillance data to identify infections (i.e., HAI and community-acquired), infection risks, communicable disease outbreaks, and to maintain or improve resident health status and to track staff for adherence to infection control policies and procedures and the potential need to for corrective action. 28 Pa Code 211.12 (c)(d)(1)(3)(5) Nursing services	F 0880		

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F 0880 SS=F	Continued from page 61 28 Pa. Code 211.10(a)(d) Resident care policies	F 0880		

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F 0880 SS=F	Continued from page 62	F 0880		
F 0885 SS=E		F 0885		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0885 SS=E	Continued from page 63 483.80(g)(3)(i)-(iii) Reporting-Residents,Representatives&Families §483.80(g) COVID-19 reporting. The facility must— §483.80(g)(3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must— (i) Not include personally identifiable information; (ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and (iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other. This REQUIREMENT is not met as evidenced by:	F 0885	1. Facility provided proof of notification with mailed letters during survey. Facility can not retroactively correct. 2.Facility can not retroactively correct and per new updates as of May 1st 2023 the facility no longer needs to notify by the end of day at 5pm. Facility will continue to make calls and mail letters to meet regulation. 3.Regional nurse consultant/Designee will educate DON/ADON on updates with new guidance as notification by 5pm is no longer required. DON/ADON will be educated on ensuring notification with COVID-19 outbreak is completed based on current process which is via phone call and or letter via mail. 4.DON/designee will audit weekly x 4 weeks than monthly x 2 months to ensure notification is completed if in a COVID-19 outbreak. Audits will be reviewed in QAPI.	Completion Date: **05/23/2023** Status: **APPROVED** Date: **05/15/2023**

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F 0885 SS=E	Continued from page 64 Based on review of select facility policy and information provided by the facility, and staff interview, it was determined that the facility failed to ensure that residents, representatives and families were timely informed of cumulative, confirmed, and suspected COVID-19 infections in the facility. Findings include: A review the facility policy entitled SARS-CoV-2 management (no review/revision date noted) revealed that the facility will "Notify staff, residents, and families promptly about identification of SARS-CoV-2 in the facility and maintain ongoing, frequent communication with staff, residents, and families with updates on the situation and facility actions." Interview with the Nursing Home Administrator on May, 2023, at approximately 3 PM revealed that the facility's practice for COVID notification is for	F 0885		

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F 0885 SS=E	Continued from page 65 the staff to mail a letter to the residents' families when a new COVID-19 infection occurs and keep them updated with COVID-19 activity in the building. Review of facility information reported to the State Licensure Agency revealed the following positive cases of COVID among facility residents and Staff Facility staff: April 11, 2023--2 staff members April 13, 2023--1 staff member April 14, 2023--1 staff member April 15, 2023--2 staff members April 17, 2023--1 staff members Facility residents: April 14, 2023--5 residents April 15, 2023--14 residents April 16, 2023--4 residents April 17, 2023--10 residents	F 0885		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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MILFORD HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: 133602	264 ROUTE 6 & 209 MILFORD, PA 18337

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F 0885 SS=E	Continued from page 66 April 18, 2023--1 residents There was no evidence that the facility had informed residents, their representatives, and families by 5:00 PM the next calendar day following the occurrence of a single confirmed infection of COVID-19 in response to this recent outbreak. Interview with the corporate nurse consultant on May 4, 2023, at approximately 3 PM confirmed that the facility had failed to timely inform and update the residents, representatives, and families of confirmed COVID infections. 28 Pa. Code 201.14(a)(e) Responsibility of Licensee 28 Pa. Code 201.18(e)(1)(2)(3) Management	F 0885		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395466	A. BLDG: __00_____ B. WING: _____	05/04/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MILFORD HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: 133602	264 ROUTE 6 & 209 MILFORD, PA 18337

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0885 SS=E	Continued from page 67	F 0885		
F 0886 SS=F		F 0886		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395466	A. BLDG: __00_____ B. WING: _____	05/04/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MILFORD HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: **133602**	**264 ROUTE 6 & 209 MILFORD, PA 18337**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0886 SS=F	Continued from page 68 483.80 (h)(1)-(6) COVID-19 Testing-Residents & Staff §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19.	F 0886	1. facility can not retroactively correct. 2.facility can not retroactively correct. Facility will have documentation of contact tracing if COVID-19 outbreak should occur. Contact tracing will be completed by infection control nurse and testing will be completed based on policy and contact tracing. 3.DON/Designee will educated ADON/ICP nurse to ensure testing is Performed and SARS-CoV-2 Viral Testing is completed when: - Anyone with even mild symptoms of COVID-19, regardless of vaccination status, should receive a viral test as soon as possible - Asymptomatic patients with close contact with someone with SARS-CoV-2 infection, regardless of vaccination status, should have a series of three viral tests for SARS-CoV-2 infection. If the date of a discrete exposure is known, testing is recommended	Completion Date: **05/23/2023** Status: **APPROVED** Date: **05/16/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395466	A. BLDG: __00_____ B. WING: _____	05/04/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MILFORD HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: 133602	264 ROUTE 6 & 209 MILFORD, PA 18337

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0886 SS=F	Continued from page 69 §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by:	F 0886	immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1, day 3, and day 5. 4.DON/Designee will audit weekly x 4 weeks than monthly x 2 months COVID-19 testing to ensure contact tracing/testing is performed and documented. Results will be reviewed in QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395466	A. BLDG: __00_____ B. WING: _____	05/04/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MILFORD HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: **133602**	**264 ROUTE 6 & 209** **MILFORD, PA 18337**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0886 SS=F	Continued from page 70	F 0886		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395466	A. BLDG: __00_____ B. WING: _____	05/04/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MILFORD HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: 133602	264 ROUTE 6 & 209 MILFORD, PA 18337

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0886 SS=F	Continued from page 71 Based on a review of resident clinical records and CMS directives, observations and staff interviews it was determined that the facility failed to conduct COVID-19 testing of facility staff according to established directives in response to a Covid-19 outbreak in the facility. Findings included: A review of the Pennsylvania Department of Health 2022 - PAHAN - 663 - 10-04-UPD dated October 4, 2022, subject: UPDATE: Interim Infection Prevention and Control. Recommendations for Healthcare Settings during the COVID-19 Pandemic. This HAN Update provides comprehensive information regarding infection prevention and control for COVID-19 in healthcare settings based on changes made by CDC on September 23, 2022. Perform SARS-CoV-2 Viral Testing: - Anyone with even mild symptoms of	F 0886		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MILFORD HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: 133602	264 ROUTE 6 & 209 MILFORD, PA 18337

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0886 SS=F	Continued from page 72 COVID-19, regardless of vaccination status, should receive a viral test as soon as possible - Asymptomatic patients with close contact with someone with SARS-CoV-2 infection, regardless of vaccination status, should have a series of three viral tests for SARS-CoV-2 infection. If the date of a discrete exposure is known, testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1, day 3, and day 5. Review of information provided by the facility during the survey ending May 4, 2023, revealed that 2 staff tested positive for COVID-19 on April 11, 2023, which initiated outbreak testing in the facility. On April 13, 2023, one additional staff tested positive for COVID-19. On April 14, 2023, one additional staff and 5 facility	F 0886		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395466	A. BLDG: 00 B. WING:	05/04/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MILFORD HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: 133602	264 ROUTE 6 & 209 MILFORD, PA 18337

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0886 SS=F	Continued from page 73 residents tested positive for COVID. On April 15, 2023, 2 staff tested positive for COVID-19 and 14 residents tested positive. On April 16, 2023, 4 residents tested positive for COVID-19. On April 17, 2023, one staff and 10 residents tested positive for COVID-19. On April 18, 2023, one staff member tested positive for COVID-19. According to the Centers for Medicare and Medicaid Services, Center for Clinical Standards and Quality/Survey & Certification Group QSO-Memo - 20-38-NH initially dated August 26, 2020, revised September 10, 2021, stated that documentation of testing includes the following: for symptomatic residents and staff, document the date(s) and time(s) of the identification of signs or symptoms, when testing was conducted, when results were obtained, and the actions the facility took based on the results. Upon identification of a new COVID-19 case in the facility, document the date the case was identified, the date that other residents and staff are tested, the dates that staff and residents who tested negative are retested, and the	F 0886		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MILFORD HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: **133602**	**264 ROUTE 6 & 209** **MILFORD, PA 18337**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0886 SS=F	Continued from page 74 results of all tests. For each instance of testing document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. A review of facility staff COVID-19 testing records revealed that the facility outbreak began on April 14, 2023. There was no evidence at the time of the survey ending May 4, 2023, of documented contract tracing used to identify potential staff requiring COVID testing. The outbreak in the facility began on April 14, 2023, on the second floor and continued through April 17, 2023. Residents tested positive for COVID were located on both the first floor and second floor of the facility and the facility failed to expand its testing based on the spread and additional positive results. Interview with Corporate Nurse consultant on May 4, 2023, at 3 PM revealed that she stated that she completed contract tracing in the facility to determine who was to be tested, but was unable to provide documentation of the contract tracing used	F 0886		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395466	A. BLDG: __00_____ B. WING: _____	05/04/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MILFORD HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: **133602**	**264 ROUTE 6 & 209 MILFORD, PA 18337**

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F 0886 SS=F	Continued from page 75 at the time of the survey to demonstrate adequate COVID testing had been conducted. There was no evidence at the time of the survey that facility wide COVID outbreak testing was completed to mitigate the spread of the the COVID -19 virus. 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services 28 Pa. Code 211.10 (a)(d) Resident care policies 28 Pa. Code 201.14 (a) Responsibility of licensee 28 Pa. Code 201.18 (e)(1)(3) Management	F 0886		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MILFORD HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: **133602**	**264 ROUTE 6 & 209** **MILFORD, PA 18337**

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P 0415	§ 201.14(d)(1)&(2) Responsibility of licensee. (d) In addition to the notification requirements in Section 51.3, the facility shall report in writing to the appropriate division of nursing care facilities field office: (1) Transfers to hospitals as a result of injuries or accidents. (2) Admissions to hospitals as a result of injuries or accidents. This REGULATION is not met as evidenced by:	P 0415	1.Facility will report into the event reporting system resident #1 transfer out. 2. Facility will do a 2 week look back to ensure any fall with transfer out is/was reported into the event report system. 3.Regional Nurse consultant/Designee will educate NHA and DON to ensure any fall that transfers out to the hospital is reported into the event reporting system. 4.NHA/Designee will audit falls weekly x 4 weeks than monthly x 2 months to ensure a fall with transfer out is reported into the event reporting system. results will be reviewed in QAPI.	Completion Date: **05/23/2023** Status: **APPROVED** Date: **05/15/2023**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE:	(X6) DATE:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395466	A. BLDG: 00 B. WING:	05/04/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MILFORD HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: **133602**	**264 ROUTE 6 & 209** **MILFORD, PA 18337**

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P 0415	Continued from page 1 Based on a review of clinical records and select incident reports and staff interview, it was determined that the facility failed to report a resident's transfer to the hospital as a result of an incident to the State Licensing Agency for one resident out of 18 sampled (Resident 1). Findings include: A review of an incident report and clinical record revealed that on April 29, 2023, at 2:10 AM Resident 1 was heard yelling. Staff responded to Resident 1's room and the resident was found lying on left side of the floor of the resident's room The physician was notified, and the resident was transferred to the hospital. The facility did not report this resident's transfer to the hospital as the result of an incident to the State Licensing Agency. Interview with the corporate nurse consultant on	P 0415		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MILFORD HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: **133602**	**264 ROUTE 6 & 209 MILFORD, PA 18337**

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P 0415	Continued from page 2 May 4, 2023, at 3 PM confirmed that the reportable incident was not reported to the State Licensing Agency.	P 0415		
P 0420		P 0420		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395466	A. BLDG: 00 B. WING:	05/04/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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P 0420	Continued from page 3 § 201.14(e) Responsibility of licensee. (e) The administrator shall notify the appropriate division of nursing care facilities field office as soon as possible, or, at the latest, within 24 hours of the incidents listed in Section 51.3 and subsection (d). This REGULATION is not met as evidenced by:	P 0420	1. Facility can not retroactively correct. Facility did report positive COVID-19 cases into the Event reporting system. 2.Facility can not retroactively correct. Facility did report positive COVID-19 cases into the Event reporting system. Facility will have the NHA/DON educated on reporting COVID-19 cases within 24 hours and have them report cases if an outbreak should occur. 3.Regional nurse consultant will educate NHA/DON to ensure COVID-19 cases are reported into the event reporting system within 24 hours. 4. NHA/Designee will audit any COVID-19 cases weekly x 4 weeks than monthly x 2 months to ensure COVID-19 cases are reported into the event reporting system within 24 hours. results will be reviewed in QAPI.	Completion Date: **05/23/2023** Status: **APPROVED** Date: **05/17/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 0420	Continued from page 4 Based on a review of clinical records and information provided by the facility and staff interviews it was determined that the facility failed to report positive cases of COVID-19 to the State Licensing Agency. Findings included: Review of information provided by the facility during the survey ending May 4, 2023, revealed that two staff tested positive for COVID-19 on April 11, 2023, which initiated outbreak testing in the facility. On April 13, 2023, one additional staff tested positive for COVID-19. On April 14, 2023, one additional staff and 5 facility residents tested positive for COVID . On April 15, 2023, 2 staff	P 0420		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 0420	Continued from page 5 tested positive for COVID-19 and 14 residents tested positive. On April 16, 2023, 4 residents tested positive for COVID-19. On April 17, 2023, one staff and 10 residents tested positive for COVID-19. On April 18, 2023, one staff member tested positive for COVID-19. The facility did not report the positive cases of COVID-19 among facility residents and staff to the State Licensing Agency. During an interview May 4, 2023 at 3 PM, the Corporate Nurse Consultant confirmed that the facility did not report the staff and residents who had tested positive for COVID-19 to the State Licensing Agency.	P 0420		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 2020		P 2020		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
P 2020	Continued from page 7 § 211.12(i) Nursing services. (i) A minimum number of general nursing care hours shall be provided for each 24-hour period. The total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 2.7 hours of direct resident care for each resident. This REGULATION is not met as evidenced by:	P 2020	1. The facility did not have any days below 2.7. The staffing direct care hours given to the surveyor did not show any days below 2.7. April 22 2023 showed a PPD above 2.70,April 24th showed a PPD of 2.70 April 27th showed a PPD of 2.70. Pay roll and staffing sheets were reviewed and calculated without error showing above 2.70 2.The facility did not have any days below 2.7. The staffing direct care hours given to the surveyor did not show any days below 2.7. Facility will ensure to give punch ins and ensure daily staffing sheets reflect hours worked. Surveyor removed RN hours who works floor 1 cart. Facility uses RN supervisor as a cart nurse and counts them in their direct care hours. ADON becomes the house supervisor if they are not working direct care hours and facility per surveyors request does not count their hours in direct care hours. 3. NHA/Designee will educate staffing coordinator and	Completion Date: 05/23/2023 Status: APPROVED Date: 05/18/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395466	A. BLDG: __00_____ B. WING: _____	05/04/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MILFORD HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: 133602	264 ROUTE 6 & 209 MILFORD, PA 18337

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
P 2020	Continued from page 8	P 2020	DON/ADON on ensuring staffing provided is at minimum of a 2.7 and staffing sheets and punch in sheets reflects all forms to ensure proper staffing hours is reflecting current direct care hours. 4.NHA/Designee will audit staffing daily x 4 weeks than monthly x 2 months to ensure facility is at minimum ppd of 2.7. results will be reviewed in QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395466	A. BLDG: 00 B. WING:	05/04/2023

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P 2020	Continued from page 9 Based on a review of nurse staffing and resident census, it was determined that the facility failed to consistently provide minimum general nursing care hours to each resident daily. Findings include: A review of the facility's weekly staffing levels revealed that on the following dates the facility failed to provide minimum nurse staffing of 2.7 hours of general nursing care to each resident: April 22, 2023 -2.65 direct care nursing hours per resident April 24, 2023 -2.37 direct care nursing hours per resident April 27, 2023 -2.54 direct care nursing hours per resident On the above noted dates, the facility	P 2020		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395466	A. BLDG: __00_____ B. WING: _____	05/04/2023

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P 2020	Continued from page 10 failed to provide a minimum 2.7 hours of direct nursing care to each resident daily.	P 2020		

Certified End Page

MILFORD HEALTHCARE AND REHABILITATION CENTER

STATE LICENSE NUMBER: 133602

SURVEY EXIT DATE: 05/04/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen, MD, FAAP
Acting Secretary of Health

pennsylvania
DEPARTMENT OF HEALTH

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY